
APPLICATION FOR INITIAL LICENSURE
Licensed Orthotist, Pedorthist, Prosthetist,
Orthotic Assistant, Prosthetic Assistant & Orthotic/Prosthetic Assistant

State of Arkansas
Orthotics, Prosthetics and Pedorthics License Application
Division of Health Facility Services
5800 W. 10th Street, Suite 400
Little Rock, Arkansas 72204
(501) 661-2201 TDD 1-800-234-4399

Please type or write legibly.

Add additional pages where needed to complete information requested.

I. BACKGROUND INFORMATION

a. PERSONAL

1. Name: _____
Last First Middle or Maiden
2. Give all previous names:

3. Mailing Address: (for Official correspondence) _____

4. Home Address if different than above: _____

5. Telephone: Home: _____ Work: _____ Cell: _____
6. Date of Birth: _____ Social Security No. _____
7. Identify all professional licenses, certificates and registrations issued by other states, jurisdictions, and territories.

License # _____ State/Entity _____

License # _____ State/Entity _____

License # _____ State/Entity _____

8. Has your license, certificate or registration ever been revoked, canceled, or suspended?

☐ yes ☐ no

9. If yes to the previous question, explain each disciplinary incident. _____

10. Have you ever been convicted of or plead guilty or nolo contendere to a felony? ☐ yes ☐ no

If yes, explain below for each.

11. Have you ever been sanctioned by either Medicare or Medicaid? ☐ yes ☐ no

If yes, give the date(s), each state or jurisdiction, and explain each below.

12. Place a checkmark by the type of **License or Permit** for which you are applying:

License

Permit

☐ (a) Orthotist

☐ (g) Temporary Orthotist

☐ (b) Prosthetist

☐ (h) Temporary Prosthetist

☐ (c) Pedorthist

☐ (i) Temporary Pedorthist

☐ (d) Orthotic Assistant

☐ (e) Prosthetic Assistant

☐ (f) Orthotic/Prosthetic Assistant

b. ASSISTANT LICENSURE EXPERIENCE INFORMATION

Three (3) years experience must be in fitting of custom orthotic or prosthetic devices.

Discipline of Application: ☐ Orthotics ☐ Prosthetics

Employer 1:

From: (mm/dd/yy) ____/____/____ To: (mm/dd/yy) ____/____/____

In the discipline of this application, list the hours worked per week: _____

Name of the facility for this period of employment:

Address _____

City

State

Zip Code

Telephone Number () ____ - ____

Direct Supervisor _____ Title _____

Employer 2:

From: (mm/dd/yy) ____/____/____ To: (mm/dd/yy) ____/____/____

In the discipline of this application, list the hours worked per week: _____

Name of the facility for this period of employment:

Address _____

City

State

Zip Code

Telephone Number () ____ - ____

Direct Supervisor _____ Title _____

Employer 3:

From: (mm/dd/yy) ____/____/____ To: (mm/dd/yy) ____/____/____

In the discipline of this application, list the hours worked per week: _____

Name of the facility for this period of employment:

Address _____

City

State

Zip Code

Telephone Number () ____-____

Direct Supervisor _____ Title _____

Employer 4:

From: (mm/dd/yy) ____/____/____ To: (mm/dd/yy) ____/____/____

In the discipline of this application, list the hours worked per week: _____

Name of the facility for this period of employment:

Address _____

City

State

Zip Code

Telephone Number () ____-____

Direct Supervisor _____ Title _____

Any experience with:☐ upper extremity prosthetics☐ lower extremity prosthetics

Give specific details of your experience:

Any experience with:☐ lower extremity orthotics☐ cervical orthotics☐ upper extremity orthotics☐ spinal orthotics

Give specific details of your experience:

*Add additional pages for additional information as needed.***c. QUALIFYING DOCUMENTATION for Assistant Licensure**

Attach written documentation from a licensed Orthotist or Prosthetist that the applicant is qualified to perform as an assistant in the field in which the person is seeking licensure as an assistant.

d. ACADEMIC INFORMATION- Complete 1-4 as applicable to your license requirements.

Orthotist & Prosthetist

Submit written evidence of:

- Baccalaureate degree or completed semester hours equivalent to 4 years of study at a 4 year college or university and
- Completed Orthotic or Prosthetic education program accredited by the Commission on Accreditation of Allied Health education Programs or its successor organization and
- Successful completion of a clinical NCOPE residency in Orthotics, Prosthetics or both
- ABCOPP certification.

Pedorthist

Submit written evidence of:

- High school diploma or GED and
- Pedorthic education program
- ABCOPP certification.

Assistants

Submit written evidence of:

- High school diploma or GED and
- Qualifying Documentation noted in b(c) on page 5.

1. Education Program_____

Location_____

Dates attended_____

2. Clinical Residency

Location_____

Dates attended_____

3. College or University _____

Location_____

Degree awarded and major field_____

Dates attended_____

College or University_____

Location_____

Degree awarded and major field_____

Dates attended_____

4. High School or GED

Location_____

Dates attended_____

II. NATIONAL CERTIFICATION:

American Board for Certification in Orthotics, Prosthetics & Pedorthics (ABCOPP)

Attach copies of Successful completion of ABCOPP certification examination:

Check each profession which you are Board Certificated:

- ☐ Orthotist
- ☐ Prosthetist
- ☐ Pedorthist

III. AFFIRMATION ON OATH

I declare that the information I have provided in this application is truthful. I understand that providing false information of any kind may: (a) void this application; and (b) may void any license or certificate issued to me based upon this application; and (c) may result in disciplinary action against me.

Date

Signature of Applicant

License Fees Please make check out to AR Dept. Health

License fee for initial licensure and renewal of licensure:

1. for the practice of Orthotics, Prosthetics, or Pedorthics, shall be three hundred dollars (\$300) every two (2) years;
2. for Orthotic Assistant, an Orthotic/Prosthetic Assistant or a Prosthetic Assistant shall be one hundred dollars (\$100) every two(2) years;
3. Late renewal \$100.00;
4. Reinstatement \$300.00;
5. Reinstatement for Assistant \$100.00.
6. All fees are non-refundable.
7. Applications without Fees & Required Information will be considered INCOMPLETE and will not be processed until all requested material is received.

Please make & keep a copy of the completed application & all requested information and **send original application, fee and all requested information to:**

Division of Health Facility Services address on first page.